Alternate Care Operating Budget Year: 2015 Fiscal Data Collection Form

Annual Expenses Name of Organization				
Program Name				
Number of Licensed Beds	0			
Direct Core Ctoff	Hours/	Total Hours		Total
Direct Care Staff 1st Shift - Weekdays	Day 0.00	Annually 0	Hourly Wage -	Wages -
2nd Shift - Weekdays	0.00	0		\$ -
3rd Shift AWAKE Weekdays	0.00	o		\$ -
3rd Shift ASLEEP Weekdays	0.00	0	\$ -	\$ -
1st Shift - Weekends	0.00	0	\$ -	\$ -
2nd Shift - Weekends	0.00	0	·	\$ -
3rd Shift AWAKE Weekends	0.00	0	·	\$ -
3rd Shift ASLEEP Weekends	0.00	0		\$ -
TOTALS	5	0		_ \$ -
Paid Off Time (Vacation, sick, holiday…) Total Direct Care Staff		0		」\$ - \$ -
Other Staff Costs				Annual
(Excluding Direct Care Staff)	# of FTE	Hours/Year	Hourly Rate	Cost
Support Staff (clerical, drivers, maintenance)	0	0	-	\$ -
Program Management Staff	0	0	-	\$ -
Nursing	0	0	-	\$ -
Supervisory Staff	0	0	-	\$ -
Executive/Administrative Staff	0	0	\$ -	\$ -
Totals Profit	0 Annual Cost	0		<u>-</u>
Profit Owner's Salar				\$
Benefits And Taxes	Annual Cost		Room and Board	Annual
Workers Compensation	\$ -			Expense
Unemployment	\$ -		Property Depreciation	\$ -
FICA	\$ -		Property Interest	\$ -
Health Insurance	\$ -		Rent	\$ -
Retirement	\$ -]	Property/Casualty Insurance	\$ -
Long Term Disability	\$ -]	Property Taxes	\$ -
Short Term Disability	\$ -	1	Building/Grounds Maintenance	\$ -
Life Insurance	\$ -	1	Maintenance Salaries	\$ -
Other-	\$ -	1	Resident Food	\$ -
Total Benefits	\$ -	#DIV/0!	Household Supplies	\$ -
Other Staff Expenses		1	Household Equipment	\$ -
Staff Training	\$ -	-	Resident Furnishings	\$ -
Staff Mileage	\$ -	1 -	Utilities	\$ -
Staff Recruitment, drug screens, background checks	\$ -	1 -	Resident Phone	\$ -
Other (please specify expense)	\$ -	1 -	Cable TV	\$ -
Total Other Staff Expenses	\$ -	1	Other Housing Costs	\$ -
Transportation	Annual		Total Room & Board/Facility	\$ -
	Expense		Total Room & Board/Person	#DIV/0!
Vehicle Depreciation (or lease)	\$ -	_	Daily Room & Board/Person	#DIV/0!
Interest	\$ -	-		
Gas, oil	\$ -] -	Expense Summary	
Repairs and Maintenance	\$ -	1 -	Total Support and Services	\$ -
Insurance	\$ -	1 -	DAILY RATE - Support	#DIV/0!
License/Permits	\$ -	1	Total Room and Board	\$ -
Public Transportation (bus & cab tickets)	\$ -	1	DAILY RATE - R & B	#DIV/0!
Other (please specify expense)	\$ -	1	Total Program Cost	\$ -
d / //	\$ -	1	DAILY RATE - Total Program	#DIV/0!
	\$ -	1	Indirect Overhead %	#DIV/0!
	\$ -			2 , 0.
Total Transportation	\$ -			
Other Operating Costs	Annual			
Office Occupancy Costs	T \$ -		Income Summary Care Support & Services	•
Office Occupancy Costs Insurance (other than property/casualty)	\$ - \$ -	1	Other Contracts	\$ - \$ -
		1		
Office supplies and furnishings Office Telephone	\$ -	· -	SSI/Room & Board Payments MAPC*	\$ - \$ -
Office Telephone Postage		· -	Hud Credit	φ -
		· -	Other	\$ -
Operating Fees/Permits/Licenses		1		Ψ
Activities as part of a documented client treatment plan	\$ - \$ -	1	Total	\$ -
Uncovered Medical Supplies & Drugs** Professional Fees	-	-	*Medical Assistance Personal Care	
Audit Fee	s \$ -	1	Modical Assistance i elsonal cale	
Legal Fee:		1		
Legal Fee: Othe		l _		
Othe Indirect Overhead Costs(please identify costs)*	\$ -	1 -		
Other (please specify expense)	<u>-</u>	· -		
Total Other Operating Costs	\$ -			
. Can Carlot Operating Cools	•	J		
Name of Person Completing the Form	T]	Number of Family Living in Facility	7
Name of Person Completing the Form Phone Number			Number of Family Living in Facility	-

Please enter data in unprotected cells. If entering a dollar amount in an "other" category, please change "other" to a descriptive name for that entry.

*If using Indirect Costs, they must be documented in an agency-wide Cost Allocation Plan

**Costs must not be covered by Title XVIII, Title XIX or other insurance coverage.

If living in the facility please see "Space Costs" section of the Allowable Cost Policy Manual.